ATTITUDES OF NURSING FACULTY TOWARD PATIENTS WITH AIDS AND PATIENTS WITH A HOMOSEXUAL LIFESTYLE

DISSERTATION

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By

Carol A. Reynolds, B.S., M.S.

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The purposes of this study were (1) to determine whether patients with AIDS are stigmatized by nursing faculty, (2) to determine whether practicing homosexuals are stigmatized by nursing faculty, (3) to determine whether faculty attitudes toward AIDS patients are influenced by the patients' sexual preference, and (4) to determine whether faculty attitudes toward practicing homosexual patients are influenced by the patients' disease. This study is a modified replication of studies by Kelly et al.

The population was nursing faculty in colleges and universities in Tarrant County, Texas. The participants were predominantly female between the ages of forty-six and fifty-five years. Seventy faculty members, 62.5% returned the data sheets.

Biographical data were gathered to determine the characteristics of the participants. Each participant received one of four vignettes describing a patient. Each vignette described a different combination of sexual preference (homosexual or heterosexual) and terminal disease (AIDS or metastatic bronchogenic lung cancer). After reading the vignette, each participant completed three evaluation inventories: the Interpersonal Attraction Inventory,

the Prejudicial Evaluation Scale, and the Social Interaction Scale. Their responses reflected their opinions of the patient after reading the vignette. The data were analyzed using a two-by-two factorial analysis of variance.

Major findings include:

1. There were no interaction effects between sexual preference and disease.

2. There were no significant differences between group mean scores on any of the three inventories regarding nursing faculty attitudes toward patients with AIDS versus patients with lung cancer.

3. There were no significant differences between group mean scores on any of the three inventories regarding nursing faculty attitudes toward homosexual and heterosexual patients.

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CHAPTER I

INTRODUCTION

Attitudes of medical personnel toward patients with Acquired Immune Deficiency Syndrome (AIDS) are a topic of increasing investigation as the incidence of AIDS increases (Kelly et al. 1987a, 1987b, 1988; Treiber, Shaw, and Malkolm 1987; Wertz et al. 1987). Attitudes toward patients with AIDS are complex and multileveled. On a physical level, medical personnel are dealing with patients who have an infectious disease which is 100 percent fatal. On an emotional level, personnel must deal with real and unfounded fears of contracting the disease as well as caring for some patients who ascribe to a lifestyle which may be morally, religiously, or socially objectionable to the caregivers (Kelly et al. 1987b, 789; Young 1988, 11).

In a set of studies, Kelly et al. (1987a, 1987b, 1988) examined the attitudes of medical students, physicians, and nurses toward persons with AIDS. Consistently and across all of the studies, participants held negative and prejudicial attitudes toward AIDS patients and toward homosexual patients regardless of their illness. Because such stigmatization carries implications for health care quality, Kelly et al. (1987a, 555) concluded that it is of utmost importance for health care educators "to develop and integrate

into teaching programs experiences which foster awareness and sensitivity of trainees toward these groups." Helping students explore their attitudes and resolve conflicts will better prepare them to deal more effectively with the growing problem of AIDS in health care.

Kelly et al. (1987a, 555) charged health care educators with the task of helping students modify any negative attitudes and biases toward AIDS patients and homosexuals. However, researchers have not examined the attitudes of educators to determine whether they hold the same negative attitudes and biases. This study, then, is a replication of Kelly et al.'s studies and examines the attitudes of nursing educators toward patients with AIDS and patients who have a homosexual lifestyle. This is an important first step toward carrying out Kelly et al.'s charge; faculty members who are aware of their own attitudes are more effective in helping students develop more positive attitudes. As Kelly (cited in Solomon 1988, 138) states, "it is first necessary to examine one's own feelings about AIDS and one's comfort level discussing issues related to AIDS."

Statement of the Problem

The problem of this study concerns the attitudes of nursing faculty toward patients with AIDS and patients with homosexual lifestyles.

Purposes of the Study

The purposes of this study are to:

1. determine whether patients with AIDS are stigmatized by nursing faculty,

2. determine whether patients with a homosexual lifestyle are stigmatized by nursing faculty,

3. determine whether faculty attitudes toward AIDS patients are influenced by the patients' sexual preference, and

4. determine whether faculty attitudes toward patients with a homosexual lifestyle are influenced by the patients' disease.

Research Questions

In order to carry out the purposes of the study, the following research questions are formulated:

1. Are there any significant differences between the attitudes of nursing faculty toward patients with AIDS and patients with metastatic bronchogenic lung cancer?

2. Are there significant differences between the attitudes of nursing faculty toward homosexual versus heterosexual patients?

3. Are the attitudes of nursing faculty toward patients with AIDS affected by patients' sexual preference?

4. Are the attitudes of nursing faculty toward patients with a homosexual lifestyle affected by the patients' disease?

Background and Significance of the Study

AIDS is a disease which has attracted national attention, not only because of its rapid spread, but because of the virtual 100 percent mortality rate for victims who have the full clinical form of the disease. There seems to be a near hysterical, but unfounded, fear that the disease can be contracted by casual contact with infected persons. These fears have not only influenced the lay population but have significantly affected health care workers' attitudes toward patients with AIDS, which in turn has affected their willingness to care for these patients (Blumenfield et al. 1987, 63; Staver 1987). For these reasons the attitudes of physicians, nurses, and other health care workers toward patients with AIDS are becoming a topic of growing concern, discussion, and investigation. This concern is increasing as the incidence of AIDS cases increases. Currently the rate of infection is rising at a startling rate. More than 50,000 cases of AIDS have been reported since the syndrome was first identified in 1981. It is projected that there will be more than 270,000 documented cases by the end of 1991, with more than 74,000 occurring in 1991 alone (Centers for Disease Control 1987a, 43).

There is, however, more to the issue of AIDS than the fear of contracting the disease through accidental exposure. Reports of studies point

to the fact that preexisting prejudices regarding homosexuality negatively influence attitudes toward patients with AIDS (Altman 1986; Kelly et al. 1987a, 1987b, 1988; Wertz et al. 1987). This is exemplified by the tendency to consider AIDS a "gay disease." These negative attitudes are found not only among the general public but also among physicians, medical students, and, to a greater degree, among nurses (Kelly et al. 1987a, 1987b, 1988). Such attitudes in the public sector are considered a social issue; however, when they appear in health care workers, especially nurses, who are on the front line of AIDS patient care, these attitudes have significant consequences.

Negative attitudes interfere with the establishment of positive, open, and non-judgmental care relationships with patients with AIDS. The patients, perceiving such attitudes, lose confidence, comfort, and trust in their care providers (van Servellen, Lewis, and Leake 1988, 7). It is believed that education about AIDS is the key to arresting its spread as well as to controlling unfounded fears of contracting the disease (Koop and Samuels 1988). Educational programs for health care givers have been implemented to address these issues, with varying degrees of success (Wertz et al. 1987, 248). Some suggest that psychological support systems must be established for health care personnel "to reduce staff discomfort and thereby facilitate optimal care of AIDS patients" (Treiber, Shaw, and Malcolm 1987, 496). The educational process must include factual information and must provide opportunities for recognizing and dealing with negative attitudes. It is a process which cannot

be left to post-graduate continuing education faculty. It must be started in schools of nursing in order to prepare new graduates to care for AIDS patients as empathetic, understanding, accepting, professional nurses (Kelly et al. 1988, 83).

Nursing faculty will be better able to help students identify their attitudes toward AIDS patients and patients with homosexual lifestyles and to deal with them in a positive manner, if, as Kelly points out, they first recognize their own attitudes toward this same population. The purpose of this study is to determine the attitudes of nursing faculty toward AIDS patients and patients with homosexual lifestyles and to determine whether they are similar to those groups of physicians, medical students, and nurses previously studied by Kelly et al. (1987a, 1987b, 1988).

Definitions

For the purpose of this study, the following terms are defined:

1. Patients with AIDS--adult males practicing either a homosexual or heterosexual lifestyle.

2. Homophobia--any negative attitude or belief regarding homosexual persons.

Delimitation of the Study

This study is limited to faculty members teaching in nursing programs in Tarrant County, Texas.

Summary and Organization of the Study

Chapter I introduced the study with a statement of the problem, the purpose, the research questions, the background and significance of the study, definitions, and limitations of the study. The further organization of the study is as follows: Chapter II presents a review of related literature addressing the epidemiological and medical aspects of AIDS, the factors affecting attitudes toward AIDS and homosexuals, the role of education in identifying and attenuating negative attitudes toward AIDS and homosexuals, the need for educators to enhance their effectiveness by recognizing and attenuating any personal negative attitudes, and, finally, the fact of any research identifying nursing educators' attitudes toward AIDS and homosexuals. Chapter III includes the methods and procedures used to collect and analyze the data obtained for this study. Chapter IV presents the statistical analysis of the data, and Chapter V includes the summary of the findings, implications, conclusions, and recommendations for further study.

CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

Acquired Immune Deficiency Syndrome (AIDS) is a lethal disease which appeared in the United States less than ten years ago. In that period of time AIDS has approached epidemic proportions and has resulted in negative attitudes by health care personnel, including nurses, toward its victims and the management of the illness.

Research findings detailing attitudes toward AIDS, patients with AIDS, and homosexuals as well as the reasons those attitudes prevail are presented in the review of literature. Further, what has been done to assist personnel to modify negative attitudes, as well as what experts believe still needs to be done, are also addressed.

Epidemiology and Medical Aspects of AIDS

AIDS was first recognized in 1981 after a number of previously healthy homosexual males were diagnosed as having two unusual illnesses. The first, Pneumocystis Carinii Pneumonia, is a virulent form of pneumonia that is seldom found in the United States. The second, Kaposi's Sarcoma, is a cancer which is endemic in Equatorial Africa but usually seen in persons of Italian or

Jewish descent over the age of sixty years in the United States (Berkow 1987, 2310).

AIDS is caused by Human Immunodeficiency Virus (HIV), a poorly understood retrovirus which causes severe immune system compromise. The disease is spread from one person to another through the transfer of body fluids containing infected cells, primarily blood and semen. This most frequently occurs when drug users share needles or when persons have sexual intercourse. Infection occurs less frequently through transfusion of contaminated blood and when an HIV positive woman bears a child (Jones, Adinolfi, and Gallis 1989, 11). Despite advances in pharmacology and basic research on the virus, the mortality rate for patients with AIDS is 100 percent and a vaccine is thought to be a number of years away (Siegel 1988, 5666).

From the first few cases described in 1981, the incidence has increased significantly and is projected to continue to increase. More than 35,000 cases in the United States were reported in 1989; 52,000 to 57,000 new cases are projected for 1990. It is anticipated that a total of 365,000 confirmed cases will be reported by the end of 1992. It is estimated that one million persons in the United States are infected with the HIV virus, many of whom are unaware of the infection. The greatest incidence is among homosexual or bisexual males (56%), thereby giving the disease the label of being a homosexual disease even though intravenous drug users account for 23 percent of the cases

(Centers for Disease Control 1990a, 81; Centers for Disease Control 1990b, 110; Centers for Disease Control 1990c, 140).

Factors Affecting Attitudes Toward AIDS and Homosexuals

The two primary factors which have an impact on the attitudes of nurses and other health care workers toward patients with AIDS are (1) the 100 percent fatality rate of the disease and (2) negative attitudes toward homosexuals commonly referred to as homophobia (Hudson and Ricketts 1980, 357). Although these factors cannot be separated because of their reciprocal influence on one another, they are discussed separately. The high fatality rate instills great fear of accidentally contracting the disease. The homophobia relates strongly to religious, moral, and social/cultural influences (Altman 1986, 65-70). The Surgeon General of the United States, C. Everett Koop, iterated these factors at a news conference held on October 22, 1986 on the occasion of presenting his report on AIDS.

> From the start, this disease has evoked highly emotional and often irrational responses. Much of the reaction could be attributed to fear of unknowns. . . . This was compounded by personal feelings regarding the groups of people primarily affected--homosexual men and intravenous drug abusers. (Koop and Samuels 1988, 8)

Fear of Contagion

The fear of contracting the disease has reached epidemic proportions and often stems from a lack of information of how AIDS is transmitted. Many

think the disease can be spread through casual contact, thereby making them fearful of speaking to or touching patients with AIDS or persons who associate with them. Such fears have generated significant discrimination against patients with AIDS and persons considered at risk for AIDS.

Discriminatory practices were verified in a study presented by the American Civil Liberties Union at the Sixth Annual Conference on AIDS held in San Francisco in June 1990. According to the report, 13,000 complaints of discrimination related to AIDS were reported between 1983 and 1988. Sixty percent of the complaints were filed by persons who were not HIV positive but were thought to be at risk due to occupation, life style, or other factors. Discrimination reports increased by 50 percent during 1988, after an 88 percent increase in 1987 (Fort Worth Star Telegram, 17 June 1990, sec. 1, p. 27).

The number of discriminatory incidents continues to increase despite dissemination of information to every household and every health care institution in the United States. In 1987 the Centers for Disease Control published Recommendations for the Prevention of HIV Transmission in Health Care Settings. Hospitals across the nation have utilized those recommendations to implement programs to educate employees regarding the epidemiology and appropriate preventive measures. In 1988 the Centers for Disease Control, under the direction of the former Surgeon General C. Everett

Koop, published and mailed to every household the pamphlet, Understanding AIDS in an effort to educate and decrease fear among the lay public.

Studies examining the attitudes of nurses and physicians have shown fear of contagion to be present among practicing as well as student physicians and nurses (Armstrong-Esther and Hewitt 1989; Kelly et al. 1987a, 1987b, 1988; Merrill, Laux, and Thornby 1989; van Servellen, Lewis, and Leake 1988; Wormser and Joline 1989). This fear persists even though they follow hospital infection control guidelines (Wallack 1989). Nurses appear to have a greater degree of fear than physicians (Kelly et al. 1988; Treiber, Shaw, and Malcolm 1987). Many nurses, including student nurses, reportedly believed they should be allowed to refuse to care for AIDS patients and, if assigned to care for AIDS patients on a regular basis, would refuse to care for the patients or would request a transfer (Blumenfield et al. 1987; Wiley, Heath, and Acklin 1988).

Homophobia

Basis of Homophobia

Homosexuality is documented throughout all of recorded human history and across all cultures. Researchers also report finding homosexuality widespread among primates and other mammals, as well as other species. It is never the predominant form of sexual behavior, but in all species the incidence is higher among males. Each society establishes the rules for sexual behavior

and then exerts enormous social pressure on individuals to conform to those established norms (Brink 1987, 16).

In the United States homosexuality is stigmatized as criminal, pathological, and immoral. It continues to be a legal issue in many states which still retain sodomy laws. Although it was removed from the list of approved psychiatric diagnoses by the American Psychiatric Association in 1973, many persons, including some nurses continue to consider it to be a mental illness (Reed, Wise, and Mann 1984). Homosexuality also poses a psychological threat to individuals regarding their sexual role identification. Psychologists find that some men use hostility and violence toward homosexuals to reassure themselves of their own sexuality (Fort Worth Star Telegram 17 June, 1990; Karr 1978; Storms 1978).

Religion plays a large role in casting moral judgement against homosexuals. The majority of churches in the United States have their theological roots in the Judeo-Christian tradition. Utilizing scriptural interpretation, theological tenets are developed to support a particular position regarding homosexual behavior (Jones 1966, 67-69). This is exemplified in a document published by the Catholic church in 1986 which stated that the Church's moral viewpoint is "founded on human reason illuminated by faith," and the "clear consistency within the Scriptures on the moral issue of homosexual behavior" (Ratzinger 1986, 2).

Religion, Allport states, is paradoxical by ascribing to the creed of Christian charity while exercising moral judgment against certain individuals (Allport 1954, 444). According to Brown, the Christian churches, because of their rigid human morality, have been the slowest to come forward in activating their theories of Christian charity with regard to the homosexual (Brown 1988, 230).

A study by Robert Altmeyer, a psychologist from the University of Manitoba, found that if persons with negative biases had positive social interactions with homosexuals, their attitudes became more positive unless the hostility was based on religion; in those cases, negative attitudes toward homosexuals were more difficult to change. Gregory Herek found that negativity is based on the belief that homosexuality "stands as a proxy for all that is evil, so hating gays is seen as a litmus test for being a moral religious person" (Fort Worth Star Telegram 17 June 1990). From this moral position the AIDS epidemic is explained in terms of God's wrath for perverse and immoral behavior (Altman 1986, 65-66).

Homophobia in Health Care Workers

A number of studies have revealed that health care workers are not immune to the alarmist information about AIDS and homophobic attitudes. In a study at New York City Hospital, 48 percent of the doctors and nurses were angry at the homosexual population and blamed their promiscuity for causing

the AIDS epidemic (Wallack 1989). Douglas, Kalman, and Kalman (1985, 1309) found that in some medical centers AIDS was nicknamed "WOG," the wrath of God. Kelly et al.'s studies of student and practicing doctors and nurses reflected homophobia as well as fear of contagion (Kelly et al. 1987a, 1987b, 1988). Several other studies have demonstrated homophobia and rejection of homosexuals by health care workers (Blumenfield et al. 1987; Katz et al. 1987; Lewis, Freeman, and Corey 1987). A study completed by Matthews et al. (1986) before there was wide-spread linking of AIDS to male homosexual behavior highlighted a problem which has significant implications for health care. It reflected that physicians had difficulty recognizing that they had prejudicial feelings toward their homosexual patients. This is consistent with Allport's general concept that most people are unaware of their own biases (Matthews et al. 1986).

Implications for Patient Care

Homophobia and prejudice have serious implications for quality patient care. The many physical needs of patients with AIDS often create a strain on nurses. AIDS patients also have marked psychological needs. They often have lost self-esteem, social support, and status; they may feel powerless, out of control, isolated, guilty, anxious, and angry (Hopp and Rogers 1989, 102-105; Jones, Adinolfi, and Gallis 1989, 9-10; National Institute of Mental Health 1986, 5; Salisbury 1986). Such psychological needs require significant personal

interaction, empathy, and intervention and are not quickly or easily addressed (Hopp and Rogers 1989, 98-105).

Royse and Birge (1987), however, found that because of a significant inverse relationship between empathy and homophobia, nurses provided inferior care and, in some instances, refused or stated they would refuse to care for patients with AIDS (Barrick 1988; Damrosch et al. 1990; Kalman et al. 1987; Morin, Charles, and Malyon 1984; Najman, Klein, and Munro 1982; Pauly and Goldstein 1970; Wallack 1989). Similar findings were noted in studies of recent graduates and student nurses (Cassells and Redman 1989; Lester and Beard 1988; Wiley, Heath, and Acklin 1988). Whether the problem is an unrecognized prejudice or an anxiety-producing homophobia, it must be managed if patients with AIDS are to receive quality care.

Role of Education

Fact-Based Programs

As the incidence of AIDS has increased, the educational emphasis in health care has been placed on presenting factual information concerning the incidence, epidemiology, and personal precautions regarding the disease. The basis for such an approach was to help alleviate irrational fears and to provide health care workers with realistic measures for protecting themselves against accidental infection. This approach is vitally important in view of the fatality rate associated with the illness. Researchers who examined the effectiveness

of such programs found that increased knowledge led to increased comfort with the diagnosis of AIDS and produced some improvement in the quality of patient care (Flaskerud, Lewis, and Shin 1989; Hartnett 1987).

Values Clarification

Wormser and Joline (1989, 183, 186) demonstrated that despite intense educational efforts to provide salient facts about AIDS, many health care professionals retained harmful attitudes toward AIDS patients. They concluded that because emotional responses do not parallel intellectual responses, standard educational methods are not likely to change attitudes significantly or quickly. Others have reiterated this idea by stating that because attitudes go beyond intellectual comprehension, education must go beyond presenting facts (Pauly and Goldstein 1970). Education must "impact the emotional, spiritual, physiological, intellectual, social, and sexual dimensions of the whole person" (Turner, McLaughlin, and Shrum 1988). It has been asserted that programs should include in-depth values clarification exercises since care givers who have biases and aversions may be unable to respond effectively and responsibly toward AIDS patients (Friedland 1988; Irish 1983; Murphy et al. 1988; Royse and Birge 1987; Solomon 1988; Turner, McLaughlin, and Shrum 1988; Wallack 1989; Young 1988).

Health care educators, including nursing educators, have a responsibility to assist students in developing the necessary skills to deal with AIDS patients

in an effective manner. This includes providing factual data addressing epidemiology, disease progression, treatment modalities, and personal protection precautions. It also means assisting students in the exploration of their personal attitudes towards AIDS and homosexuals. Resolution of these conflicts decreases personal stress and conflict and enhances therapeutic interactions with patients (Armstrong-Esther and Hewitt 1989, 932; Hartnett 1987, 67; Kelly et al. 1988, 83; Lester and Beard 1988, 403; Reed, Wise, and Mann 1984, 156; Solomon 1988, 140; van Servellen, Lewis, and Leake 1988, 8; Wallack 1989, 510; Wertz et al. 1987, 253; Wiley, Heath, and Acklin 1988, 245).

Schools of nursing have integrated concepts related to AIDS throughout their curricula (Cassells and Redman 1989). Studies have been completed verifying the existence of negative attitudes among nursing students toward patients with AIDS and homosexuals. Those studies and feedback from AIDS patients indicate that such biases have impaired therapeutic relationships and have been detrimental to quality patient care.

Despite the urgings of several authors (Cooke and Sande 1989; van Servellen et al. 1988; Wallack 1989), there is little evidence in the literature to indicate that much has been done to deal with prejudices toward patients with AIDS and homosexual patients. Turner, McLaughlin, and Shrum (1988) emphasize that values clarification may need to be addressed at the outset of the educational process because negative attitudes can be a barrier to

learning. They further state that to be effective, educators must maintain a non-judgmental attitude when assisting students in values clarification exercises. This is difficult, Selwyn (1986) points out, if the faculty themselves possess prejudices and negative attitudes toward patients with AIDS and homosexuals patients.

It is not clear whether faculty members possess the same biases and prejudices found in the general public and among health care givers. Reviews of the literature by several researchers reveal that this question has not been addressed and indicate a need for investigating faculty attitudes (Kelly et al. 1987a, 1987b, 1988; Lester and Beard 1988).

Summary

Selected literature related to attitudes of health care personnel toward patients with AIDS and patients with a homosexual lifestyle was examined. Included in the review were the following topics: the epidemiology and incidence of AIDS, factors affecting attitudes toward patients with AIDS and male homosexual patients, the effects of negative attitudes on patient care, and the role of education in attenuating those negative attitudes.

AIDS is presently at an epidemic stage with the Centers for Disease Control projecting significant increases in the incidence of AIDS over the next several years. As noted earlier, the highest incidence of AIDS is found among homosexual males and intravenous drug abusers.

Researchers have demonstrated that negative attitudes toward patients with AIDS and patients with a homosexual lifestyle are based on two factors. The first is fear of contagion because of the high fatality rate of AIDS as well as some uncertainty as to the ease of transmission. The second factor is homophobia, which has come to include fear of, as well as prejudice against, homosexuals on cultural, psychological, moral, and religious grounds (Altman 1986; Brink 1987; Karr 1978; Ratzinger 1986). Such attitudes have been found among care givers and have a deleterious effect on the quality of care rendered to these patients (Barrick 1988; Damrosch et al. 1990; Kalman et al. 1987; Najman, Klein, and Munro 1982; Pauly and Goldstein 1970; Wallach 1989).

Factual information regarding AIDS has been added to nursing curricula. Such additions have decreased the fear of contagion and have contributed to some degree to modifying negative attitudes (Flaskerud, Lewis, and Shin 1989; Hartnett 1987). Facts alone, however, are not sufficient to alter prejudiced minds. Attitudes are not limited to the intellect but rather involve the emotional, spiritual, intellectual, and sexual dimensions of the individual (Pauly and Goldstein 1970; Turner, McLaughlin, and Shrum 1988; Wormser and Joline 1989).

A number of researchers have suggested values clarification as an effective method of attenuating negative attitudes among nurses and health care workers and subsequently improving the quality of patient care. Faculty

must maintain a non-judgmental attitude if they are to be effective in assisting students in values clarification exercises. This may be difficult to accomplish if the faculty members have not explored and addressed any prejudices they may have (Keeling 1987; Selwyn 1986). Extensive review of the literature revealed no studies which examined faculty attitudes.

CHAPTER III

METHODS FOR THE STUDY

This study is designed to determine whether patients with Acquired Immune Deficiency Syndrome (AIDS) are stigmatized by nursing faculty; whether male patients with a homosexual lifestyle are stigmatized by nursing faculty; whether male patients with AIDS, regardless of their sexual preference, are stigmatized by nursing faculty; and whether male patients with a homosexual lifestyle and with a diagnosis of metastatic bronchogenic lung cancer are stigmatized by nursing faculty. For the purposes of this study, patients with AIDS included only adult males and patients with a homosexual lifestyle included only adult males.

Subjects

This study was restricted to nursing faculty in colleges and universities in Tarrant County, Texas. The schools represented a cross section of nursing programs: associate, baccalaureate, and master's degrees in both public and private institutions. Each program was accredited by the National League for Nursing, which is the official accrediting agency for nursing education in the United States. It is assumed that an assurance of underlying program quality,

independent of geographic location or governing body of the schools, is provided by the accrediting process.

Data Collection Procedures

A list of all faculty members was requested from the deans of the participating schools (Appendix A). After receiving the list of faculty members, individual requests for participation were sent to each of the 112 full-time and part-time faculty members. A packet of materials was mailed to each faculty member at his or her school address. The packet included a letter requesting participation and providing an explanation and instructions (Appendix B), a biographical data sheet (Appendix C), one of four vignettes describing a patient (Appendix D), and a set of three evaluation inventories with instructions (Appendix E) on which the participants recorded their impressions of the patient described in the vignette.

Each faculty member was asked to complete the biographical data sheet, read the vignette, and complete the evaluation inventories based on his or her opinions of the patient described in the vignette. Stamped, self-addressed envelopes were provided for returning the completed inventories and biographical data sheets.

Instruments

Three types of instruments were included. The first addressed personal information about the participants. The second was a vignette describing a patient. The third was a set of inventories designed to elicit information regarding the participants' attitudes toward patients described in the vignette.

Biographical Data Sheet

The Biographical Data Sheet (Appendix C) was designed to determine the characteristics of the participants. The items included personal, professional, and faculty-related information.

Vignettes

Each faculty member was given one of four vignettes describing a patient named Mark (Appendix D). Each vignette described a different combination of lifestyle and terminal illness. They included a homosexual male with AIDS (Mark/Robert), a homosexual male with metastatic bronchogenic lung cancer (Mark/Robert), a heterosexual male with AIDS (Mark/Roberta), and a heterosexual male with metastatic bronchogenic lung cancer (Mark/Roberta). The vignettes were originally designed and used by Kelly et al. (1987a, 1987b, 1988) to study the attitudes of physicians, nurses, and medical students toward patients with AIDS and patients with a homosexual lifestyle. Based on suggestions from Kelly (personal communication,

September 1988) and the dissertation committee, the vignettes were modified for this study.

In the original vignettes, leukemia was used as one of the terminal diseases. Kelly (personal communication, September 1988) stated that leukemia was not an optimal choice for the terminal illness, because leukemia could not be related to poor personal health habits or behaviors, and no personal blame or responsibility for the disease could be attributed to the patient. Additionally, many leukemias have high cure and survival rates. Metastatic bronchogenic lung cancer was substituted because studies show a greater than 90 percent correlation in males between smoking and this type of cancer. Therefore metastatic lung cancer is related to poor personal health habits of the patients. Studies further show that patients' survival rate is approximately nine months if untreated. The five year survival rate is less than 10 percent (Berkow 1987, 705, 708).

The second modification was to change the wording in the homosexual/AIDS patient vignette to make it obvious that Mark was homosexual rather than leave to chance that the participant would make the assumption of homosexuality. This was done by describing Mark's friend Robert as his "life partner." The vignette describing the heterosexual AIDS patient was likewise modified to obviate Mark's heterosexual lifestyle. This was done by stating that he contracted AIDS through a blood transfusion.

Each participant was asked to read the 500-word description of the patient named Mark. In the vignettes, Mark is described as a college graduate who, through hard work, advanced in management of the computer firm where he is employed. Mark is further depicted as a physically active person who jogs, sails, plays tennis, and enjoys skiing. In the vignette's second paragraph, an illness characterized by fatigue, physical decline, and recurrent infection that led Mark to consult his physician is described. The consequences of his illness are then detailed, including friends' discomfort with Mark's life-threatening disease, the personal drain of coping with his illness, and Mark's increasing sense of isolation and loneliness. Mark is described as having a longstanding romantic partner. While the seriousness of Mark's condition initially draws them closer, the partner eventually becomes increasingly distant and removed from Mark. The last section of the vignette describes Mark's increasing sense of isolation from his family members and their difficulty in adjusting to his illness.

The vignettes are markedly similar in content and narrative with two exceptions: Mark's illness is labeled as either AIDS or metastatic bronchogenic lung cancer and his romantic partners is identified either as Robert or Roberta. Thus, each participant read a single vignette which described either a homosexual or heterosexual male diagnosed with either AIDS or metastatic bronchogenic lung cancer. The four vignettes, labelled A,

B, C, D, were assigned sequentially to the alphabetized list of names from each school of nursing.

Evaluation Inventories

After reading the vignette, each participant was asked to complete three evaluation inventories: the Interpersonal Attraction Inventory, the Prejudicial Evaluation Scale, and the Social Interaction Scale (Appendix E). Each inventory has multiple items and each item is measured by a seven-point Likert-type scale. The participants were to respond to each item, selecting the number along the seven-point Likert-type scale which best reflected their opinions of Mark after reading the vignette.

Interpersonal Attraction Inventory

The Interpersonal Attraction Inventory, which was used by Kelly in his studies, consists of twenty-four adjective descriptors previously shown to be sensitive to interpersonal attraction and likability (Anderson 1968). Sample Interpersonal Attraction Inventory items include the following attributes: assertive, appropriate, offensive, thoughtful, intelligent, educated, truthful, warm, and kind. Each scale adjective on the Interpersonal Attraction Inventory is rated using a seven-point Likert-type scale with bipolar ratings. The participants were asked to read each set of adjective descriptors and select the number along the scale which best reflected their perception of these characteristics in Mark.

Prejudicial Evaluation Scale

The Prejudicial Evaluation Scale is a twelve item scale consisting of items adapted by Kelly from previous research assessing harsh interpersonal judgments of victims (Malmuth, Haber, and Feshback 1980) as well as anecdotal reports by Kelly describing negative attitudes that some AIDS victims have encountered. The participants were asked to read each item and select a number along the seven-point Likert-type scale which reflected the degree to which they agreed or disagreed with each judgmental statement about Mark.

Social Interaction Scale

The Social Interaction Scale is a seven item scale devised and used by Kelly et al. (1987a, 1987b, 1988) which describes possible casual interactions that might take place with Mark. The participants were asked to read each statement and select a number along the seven-point Likert-type scale which reflected the degree to which they were willing to interact in each of the described casual interactions.

Procedures for Analysis of Data

Biographical Data

Biographical data were compiled on the participants as one group. No attempt was made to separate faculty by school. The data are displayed in frequency tables.

Analysis of Inventories

A two-by-two analysis of variance was performed on the scores of the prejudicial evaluation scale, on the social interaction scale, and on the interpersonal attraction inventory to determine whether there was significant variability in the four cells: homosexual, heterosexual, AIDS, and metastatic bronchogenic lung cancer.

Examination for differences between the AIDS and metastatic bronchogenic lung portrayals (main effects for disease) was done to establish stigmas associated with illness. Examination of differences between homosexual and heterosexual portrayals (main effects for sexual preference) was done to establish stigmas associated with life style. The four portrayals (AIDS/homosexual, AIDS/heterosexual, metastatic bronchogenic lung cancer/homosexual, and metastatic bronchogenic lung cancer/heterosexual) were examined to determine whether disease and sexual preference as portrayed in the vignettes statistically interacted with one another to influence participant attitudes.

The Interpersonal Attraction Inventory scores for each of the vignettes were averaged. These averages were analyzed using a two-by-two analysis of variance to determine any negative attitudes regarding interpersonal attraction by the participants regarding illness and sexual preference and to demonstrate any interaction between illness and sexual preference.

The Prejudicial Evaluation Scale scores for each of the four vignettes were averaged. The averages were analyzed using a two-by-two analysis of variance to determine any prejudice associated with illness and sexual preference and to demonstrate any interaction between the illness and sexual preference.

The Social Interaction Scale scores for each of the four vignettes were averaged. The averages were analyzed using a two-by-two analysis of variance to determine any prejudice associated with illness and sexual preference and to demonstrate any interaction between the illness and sexual preference.

Summary

The procedures used for collecting and analyzing the data for this study are described in this study. Each participant was asked to complete a biographical data sheet, read an assigned patient vignette, and complete three inventories, evaluating the patient described in the vignette. Biographical data were compiled and displayed in frequency tables. Data from the evaluation inventories were analyzed statistically, using a two-by-two analysis of variance.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Introduction

The purpose of this chapter is to present the findings resulting from an analysis of data reflecting the attitudes of nursing faculty toward patients with Acquired Immune Deficiency Syndrome (AIDS) and toward patients with a homosexual lifestyle. This study replicates studies by Kelly et al. in which the attitudes of practicing physicians, medical students, and practicing nurses toward patients with AIDS and patients with a homosexual lifestyle were examined (1987a, 1987b, 1988).

A packet containing a biographical data sheet (Appendix C), one of four patient vignettes (Appendix D), and three Patient Evaluation Inventories (Appendix E) was sent to all 112 full-time and part-time nursing faculty at colleges and universities in Tarrant County, Texas. This population represented associate, baccalaureate, and graduate programs in public and private institutions. Seventy faculty members, 62.5 percent, returned the data sheets. Only one of the respondents did not complete the biographical data sheet.

Biographical data are presented to describe characteristics of the population. Data from the three Evaluation Inventories are examined and related to the research questions which are listed in Chapter I.

On Inventory I, the Interpersonal Attraction Inventory, participants were asked to rate the patient on various attributes using a seven-point Likert-type scale. Some of the items were reversed (opposite valence), to encourage thoughtful score selections by participants. When analyzing the data, scores for each item were obtained by reversing the scale for opposite valence questions, then taking the average rating. The scale was rearranged so that positive attributes were scored as one, and the negative of these attributes were scored as seven. The average of all ratings was an index of the participants' perceptions of the patient. Lower scores indicate that the subjects generally viewed the patient with a favorable attitude and higher scores indicate that the participants generally viewed the patient with an unfavorable or negative attitude.

Inventory II, the Prejudicial Evaluation Scale, consists of a series of statements, with which the participants were asked to agree (7) or disagree (1). The questions were phrased so that positive and negative valence were represented by approximately one-half of the questions. Responses to the questions were reversed so that lower scores indicated a more positive attitude toward the patient and higher scores indicated a more negative prejudicial attitude.

Inventory III, the Social Interaction Scale, consists of a series of statements, with which the participants were asked to agree (7) or disagree (1). The questions regarded participants' willingness to interact with the patient in a variety of social situations. The questions were arranged so that higher scores indicated less fear and greater willingness to interact socially with the patient, while lower scores indicated a higher degree of fear and an unwillingness to interact socially.

In order to determine the stigma associated with AIDS and the homosexual lifestyle, participants' ratings on the three inventories were analyzed with a Disease Type (AIDS or Cancer) times Sexual Preference (Homosexual or Heterosexual) (2 x 2) factorial analysis of variance as diagrammed in Figure 1.

Differences between group means of the AIDS and cancer portrayals (between row 1 and row 2) established a negative attitude associated with the illness; differences between the homosexual and heterosexual portrayals (column 1 and column 2) established a negative attitude associated with sexual preference. Differences between the group means of the four portrayals, rows and columns (AIDS/homosexual, AIDS/heterosexual, cancer/homosexual, cancer/heterosexual) in combination would indicate that the disease and sexual preference as portrayed in the vignettes interacted with one another to influence subjects' attitudes. A probability of .05 was set as the level of significance.

Columns = Lifestyle Factor

Rows = Disease Factor

	Column 1 Homosexual	Column 2 Heterosexual
Row 1: AIDS	Group Mean	Group Mean
Row 2: CANCER	Group Mean	Group Mean

Fig. 1. Two-by-two factorial design utilized on evaluation inventories.

The number of subjects in each of the four conditions (AIDS/Homosexual, AIDS/Heterosexual, Cancer/Homosexual, Cancer/Heterosexual) were unequal, therefore Type III sum of squares was used in the analysis as a control. Type III sum of squares are calculated using the unweighted least squares method, which minimizes the effect of unequal group sizes.

Description of Population

Biographical data are summarized in order to describe the predominant characteristics of the population. These data include biological characteristics, religious preference, years in nursing practice, academic preparation, teaching experience, and hours and location of clinical practice. The following biographical data presentation reflects the predominant characteristics of the participants and is not reflective of all data.

The typical participant was a female between forty-six and fifty-five years of age and belonged to a Protestant denomination. Academically, the typical participant graduated from a baccalaureate program in nursing more than twenty years ago and holds a master's degree in nursing. Medical-surgical was the most commonly reported graduate clinical specialty. If the participant holds a doctorate it might or might not be in the field of nursing. As a faculty member, the participant had taught nursing in a baccalaureate program in a public institution for ten years or more. The participant also engaged in clinical nursing practice, usually in the hospital setting. As a faculty member, the participant worked with students in the clinical area six to fifteen hours a week; the participant might be engaged in private clinical practice.

Data Analysis

The group means were tested using a two-by-two factorial analysis of variance to determine whether differences in attitudes toward the AIDS and cancer portrayals were significant and whether differences in attitudes toward patients in the homosexual and heterosexual portrayals were significant. In the tables which follow, the disease factor refers to group mean differences in attitudes toward patients with AIDS and toward patients with cancer. Sexual preference refers to group mean differences in attitudes toward homosexual patients compared to heterosexual patients. Disease times sexual preference refers to the analysis for statistical interaction among the four group means. This step provides data regarding the influence of each factor upon other factors. Results of this data analysis are reported according to each of the research questions.

Attitudes of Nursing Faculty Toward Patients with AIDS

Research Question One asked whether significant differences existed between the attitudes of nursing faculty toward patients with AIDS and patients with cancer. A two-by-two factorial analysis of variance was used to determine whether attitudes toward AIDS patients differed significantly from attitudes toward cancer patients. This statistical analysis examines the differences between mean scores of the respondents to the AIDS portrayal with the mean scores of the respondents to the cancer portrayals in each of the

with the mean scores of the respondents to the cancer portrayals in each of the three inventories. These analyses are presented in Table 1.

TABLE 1

COMPARISON OF ATTITUDES OF NURSING FACULTY TOWARD PATIENTS WITH AIDS VERSUS PATIENTS WITH CANCER

Inventory Type	Factor	DF	Type III SS	F	Significance Level
Interpersonal Attraction Inventory	Disease	1	1.08938755	3.25	0.0759*
Prejudicial Evaluation Scale	Disease	1	0.50391234	1.03	0.3145*
Social Interaction Scale	Disease	1	0.11891597	.16	0.6868*

*No significant difference.

No significant differences between mean scores for AIDS and cancer were found in any of the inventories; thus, the group mean scores in each inventory were examined for polarity. Group mean scores for disease in each evaluation inventory were plotted along the Likert-type scale to determine

polarity (Figure 2). Each AIDS score was compared to the associated cancer score to determine whether attitudes toward AIDS were more negative.

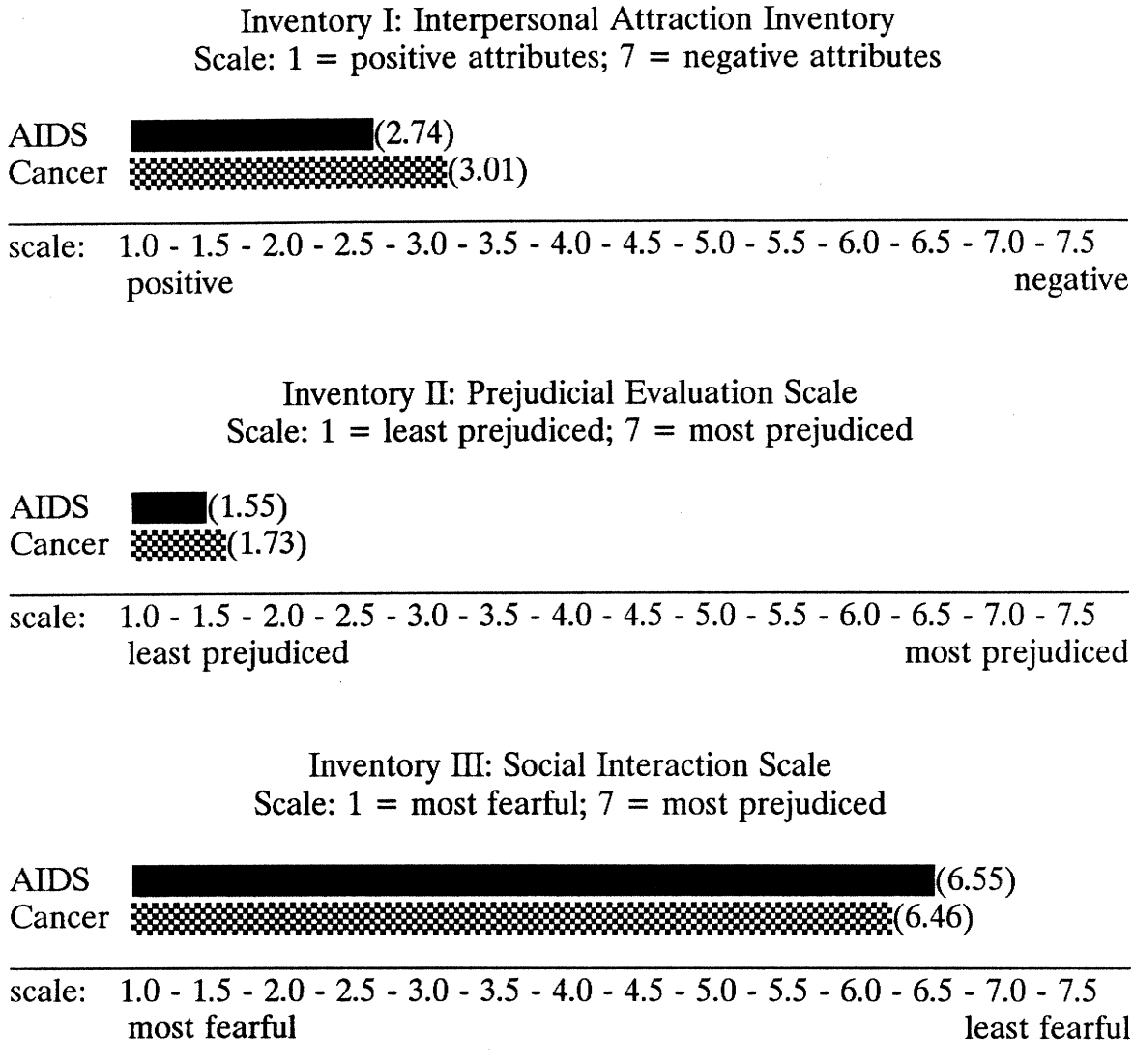

Fig. 2. Average group scores for evaluation inventories for AIDS patients versus cancer patients.

Greater negativity in AIDS scores indicates a more negative attitude toward patients with AIDS.

Mean scores for both diseases in each of the three inventories registered on the positive side of the scale; AIDS scores registered more positive than cancer scores. This result indicates that nursing faculty thought more highly of, were less prejudicial to, and less fearful of social interaction with AIDS patients than cancer patients, though these differences were not significant.

Attitudes of Nursing Faculty Toward Homosexual Patients

Research Question Two asked whether significant differences existed between attitudes of nursing faculty toward homosexual and heterosexual patients. A two-by-two factorial analysis of variance was used to determine whether attitudes toward homosexual patients differed significantly from attitudes toward heterosexual patients. This statistical analysis examines the differences between mean scores of the homosexual portrayals and the mean scores of the heterosexual portrayals in each of the three inventories. These analyses are presented in Table 2.

No significant differences in attitude were found. Thus, the group mean scores in each inventory were examined for polarity. The group mean scores for sexual preference in each evaluation inventory were plotted along the Likert-type scale to determine polarity (Figure 3). Each homosexual score was compared to the associated heterosexual score in order to determine whether

attitudes toward homosexuals were more negative. Greater negativity in homosexual scores indicates a more negative attitude toward homosexual patients.

TABLE 2

COMPARISON OF ATTITUDES OF NURSING FACULTY TOWARD HOMOSEXUAL PATIENTS VERSUS HETEROSEXUAL PATIENTS

Inventory Type	Factor	DF	Type III SS	F	Significance Level
Interpersonal Attraction Inventory	Sexual Preference	1	1.08046830	0.05	0.8171*
Prejudicial Evaluation Scale	Sexual Preference	1	0.01574380	0.03	0.8584*
Social Interaction Scale	Sexual Preference	1	0.06495922	0.09	0.7657*

*No significant difference.

Mean scores for both sexual preferences in each of the three inventories registered on the positive side of the scale. Homosexual scores on Inventory I, the Interpersonal Attraction Inventory indicate that participants had more

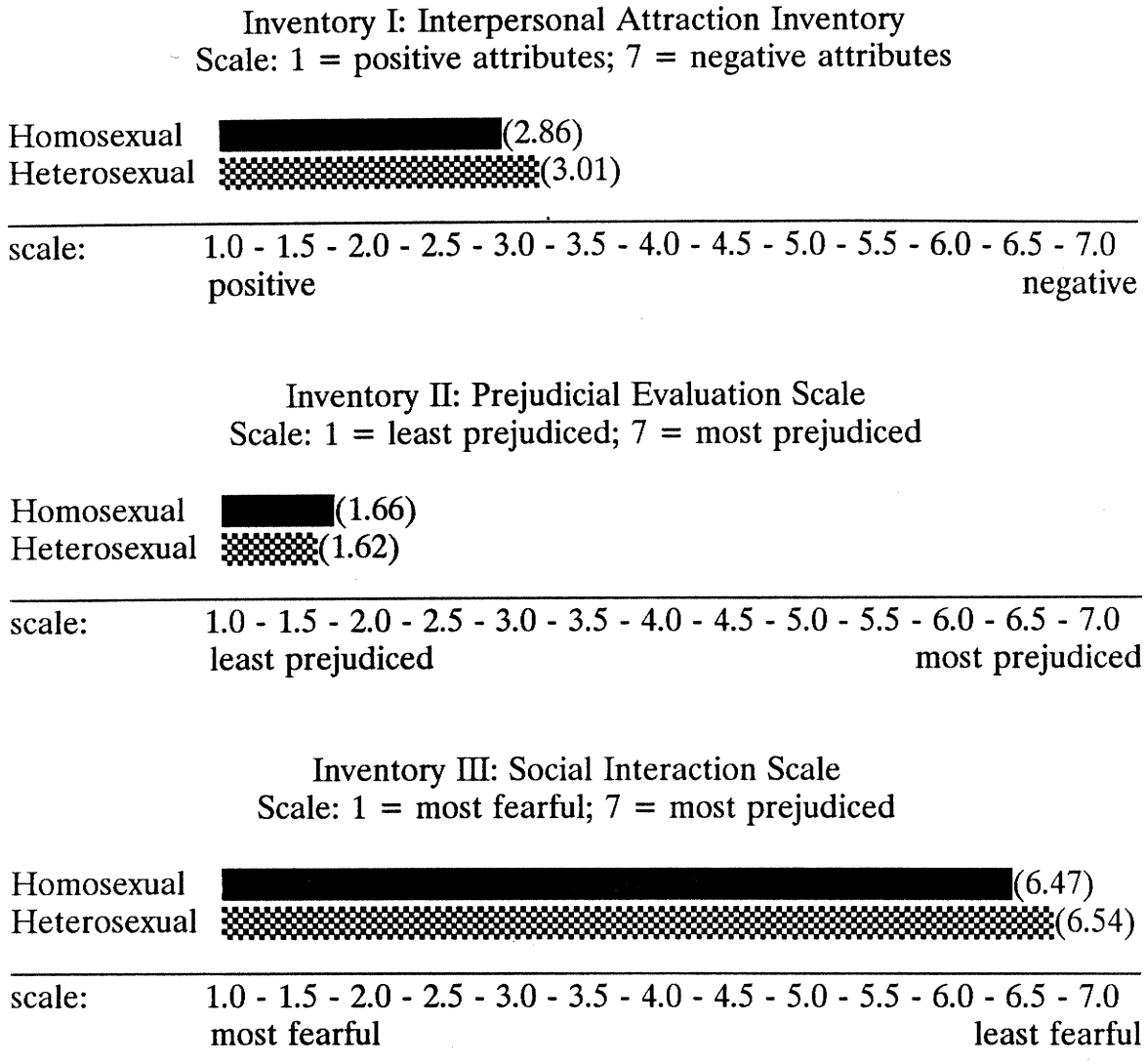

Fig. 3. Average group scores for evaluation inventories for homosexual versus heterosexual patients.

positive attitudes toward homosexual patients than heterosexual patients. Homosexual scores for Inventory II, the Prejudicial Evaluation Inventory and Inventory III, the Social Interaction Scale, indicate that participants were more

prejudiced and more fearful of social interaction with homosexual patients than toward heterosexual patients, though these differences were not significant.

Interaction of Attitudes Regarding Lifestyle on Attitudes Toward Disease

Research Question Three asked whether the attitudes of nursing faculty toward patients with AIDS were influenced by their attitudes toward the patient's lifestyle. This interaction effect is determined by comparing the means for each portrayal (AIDS/homosexual, AIDS/heterosexual, cancer/homosexual, and cancer/heterosexual) in the three Evaluation Inventories. Differences in group means (interaction effect) indicate that participants' attitudes toward patients with AIDS were influenced by the participants' attitudes toward the patient's lifestyle. Analysis for interaction on the three inventories are presented in Table 3.

No differences in means (no interaction) on any of the three evaluation inventories were found. Attitudes toward disease were not affected by attitudes toward lifestyle; therefore, faculty attitudes toward patients with AIDS were not negatively affected by their attitudes toward the patient's lifestyle.

TABLE 3

INTERACTION OF ATTITUDES OF NURSING FACULTY TOWARD DISEASE AND LIFESTYLE

Inventory Type	Factor	DF	Type III SS	F	Significance Level
Interpersonal Attraction Inventory	Disease x Preference	1	0.37149605	1.11	0.2961*
Prejudicial Evaluation Scale	Disease x Preference	1	1.23519468	2.52	0.1174*
Social Interaction Scale	Disease x Preference	1	0.17724881	0.24	0.6227*

*No significant difference.

Interaction of Attitudes Regarding Disease on Attitudes Toward Lifestyle

Research Question Four asked whether the attitudes of nursing faculty toward patients with a homosexual lifestyle were affected by their attitude toward the patient's illness. This interaction effect is determined by comparing the means for each portrayal (AIDS/homosexual, AIDS/heterosexual, cancer/homosexual, and cancer/heterosexual) in the three Evaluation

Inventories. Differences in group means (interaction effect) indicate that participants' attitudes toward the patient's lifestyle are influenced by their attitudes toward the patient's illness. Analysis for interaction on the three inventories are presented in Table 3.

There are no differences in means (no interaction) on any of the three evaluation inventories. Attitudes toward life style were not affected by attitudes toward disease; therefore, faculty attitudes toward patients with AIDS were not negatively affected by their attitudes toward the patient's lifestyle.

Discussion of Findings

The findings of this study are contrary to those obtained by Kelly et al. when they examined the attitudes of physicians, medical students, and nurses (1987a, 1987b, 1988). Such differences may be related to size of the population; Kelly et al. had a greater number of participants in their studies.

The gender of the participants may account for some differences. Studies by Kelly et al. had a larger percentage of male participants in their studies.

The change in study design may also account for results differing from those in studies by Kelly et al. Kelly et al. compared leukemia to AIDS. Leukemia is not always a fatal disease. Leukemia is also not related to personal health habits. In this study, bronchogenic lung cancer was chosen

because, like AIDS, it is tied directly to personal health habits and it too has a high fatality rate.

Fear of contagion is often a source for negative attitudes toward patients with AIDS (Armstrong-Esther and Hewitt 1989; Merrill 1989; van Servellen, Lewis, and Leake 1988; Wormser and Joline 1989). Although a large percentage of faculty members engage in instructional (75.4%) and private (44.2%) clinical practice, this did not appear to have an impact on their attitudes toward patients with AIDS. Perhaps it is necessary to determine if their practice involved caring for AIDS patients and if that clinical practice involved direct physical care of patients. A lack of direct physical contact with AIDS patients may lessen fears of contagion and, subsequently, decrease negative attitudes toward patients with AIDS.

More has been learned about AIDS since Kelly et al.'s studies. Nursing faculty may manifest more positive attitudes toward patients with AIDS because their increased knowledge regarding the disease and its epidemiology has decreased the fear of contagion. This is supported by Lawrence and Lawrence (1989) who found a positive relationship between knowledge of and attitudes about AIDS. They also found that nurses with graduate degrees had the highest knowledge base and the most positive attitudes about AIDS.

Summary

The following major findings were derived from the analysis of data for this study:

1. There were no significant differences between group mean scores regarding nursing faculty attitudes toward patients with AIDS versus patients with lung cancer on the Interpersonal Attraction Inventory, the Prejudicial Evaluation Scale, or the Social Interaction Scale.

2. There were no significant differences between group mean scores regarding nursing faculty attitudes toward homosexual and heterosexual patients on the Interpersonal Attraction Inventory, the Prejudicial Evaluation Scale, or the Social Interaction Scale.

3. There were no interaction effects among the four groups in the Interpersonal Attraction Inventory, the Prejudicial Evaluation Scale, or the Social Interaction Scale. No interaction indicates that attitudes toward disease were not influenced by attitudes toward sexual preference.

4. There were no interaction effects among the four groups in the Interpersonal Attraction Inventory, the Prejudicial Evaluation Scale, or the Social Interaction Scale. No interaction indicates that attitudes toward sexual preference were not influenced by attitudes toward disease.

CHAPTER V

SUMMARY, FINDINGS, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS FOR FUTURE RESEARCH

This chapter summarizes the purposes, methods, and procedures, analyses of the data, and the findings of this study. Conclusions, implications, and recommendations based upon the findings are also presented.

Summary

The problem of this study was to determine the attitudes of nursing faculty toward patients with AIDS and toward patients with a homosexual lifestyle. The study replicates earlier studies by Kelly et al. in which the attitudes of physicians, medical students, and nurses toward patients with AIDS and patients with a homosexual life style were studied.

This study was designed to determine whether patients with AIDS are stigmatized by nursing faculty; whether patients with a homosexual life style are stigmatized by nursing faculty; whether patients with AIDS, regardless of their sexual preference, are stigmatized by nursing faculty; and whether patients with a homosexual life style and a diagnosis of metastatic bronchogenic lung cancer are stigmatized by nursing faculty.

Nursing faculty from colleges and universities in Tarrant County, Texas served as the population for this study. Lists of faculty members were requested from the deans of the participating schools. Individual requests for participation were sent to each of the 112 full-time and part-time faculty members on the lists.

Each faculty member was asked to complete a biographical data sheet, read a vignette describing a patient, and complete three evaluation inventories based on their opinions of the patient described in the vignette. From the population of 112, 70, or 62.5 percent, participated.

Biographical data were tabulated to describe the predominant characteristics of the participants. A two-by-two factorial analysis of variance was used to treat the data from the Evaluation Inventories to determine if significant differences existed between attitudes toward AIDS patients and attitudes toward cancer patients between attitudes toward homosexual and heterosexual patients.

Summary of Major Findings

The following major findings were derived from the analysis of data for this study:

1. There were no significant differences between group mean scores regarding nursing faculty attitudes toward patients with AIDS and toward

patients with cancer on the Interpersonal Attraction Inventory, the Prejudicial Evaluation Scale, or the Social Interaction Scale.

2. There were no significant differences between group mean scores regarding nursing faculty attitudes toward homosexual and toward heterosexual patients on the Interpersonal Attraction Inventory, the Prejudicial Evaluation Scale, or the Social Interaction Scale.

3. There were no interaction effects among the four groups in the Interpersonal Attraction Inventory, the Prejudicial Evaluation Scale, or the Social Interaction Scale. No interaction indicates that attitudes toward disease were not influenced by attitudes toward lifestyle.

4. There were no interaction effects among the four groups in the Interpersonal Attraction Inventory, the Prejudicial Evaluation Scale, or the Social Interaction Scale. No interaction indicates that attitudes toward lifestyle were not influenced by attitudes toward disease.

Conclusions

Based on the major findings of this study, the following conclusions are offered:

1. Attitudes of nursing faculty toward patients with AIDS do not appear to differ significantly from their attitudes toward patients with cancer.

2. Nursing faculty attitudes toward patients with AIDS appear to be somewhat, but not significantly, more positive than their attitudes toward patients with cancer.

3. Attitudes of nursing faculty toward patients with a homosexual life style do not appear to differ significantly from their attitudes toward patients with a heterosexual life style.

4. Nursing faculty appear to have positive attitudes toward homosexual patients. They appear to be more positive toward homosexual patients than heterosexual patients, but not significantly so, regarding interpersonal attraction. They appear to be more prejudiced and more fearful of social interaction with homosexual patients than heterosexual patients, but not to a significant degree.

5. Nursing faculty attitudes toward patients with AIDS do not seem to be influenced, either positively or negatively, by the patient's sexual preference.

6. Nursing faculty attitudes toward homosexual patients do not seem to be influenced, either positively or negatively, by the patient's disease.

Discussion of Findings

The findings of this study are contrary to those obtained by Kelly et al. when they examined the attitudes of physicians, medical students, and nurses (1987a, 1987b, 1988). Such differences may be related to size of the population; Kelly et al. had a greater number of participants in their studies.

The gender of the participants may account for some differences. Studies by Kelly et al. had a larger percentage of male participants in their studies.

The change in study design may also account for results differing from those in studies by Kelly et al. Kelly et al. compared leukemia to AIDS. Leukemia is not always a fatal disease. Leukemia is also not related to personal health habits. In this study, bronchogenic lung cancer was chosen because, like AIDS, it is tied directly to personal health habits and it too has a high fatality rate.

Fear of contagion is often a source for negative attitudes toward patients with AIDS (Armstrong-Esther and Hewitt 1989; Merrill 1989; van Servellen, Lewis, and Leake 1988; Wormser and Joline 1989). Although a large percentage of faculty members engage in instructional (75.4%) and private (44.2%) clinical practice, this did not appear to have an impact on their attitudes toward patients with AIDS. Perhaps it is necessary to determine if their practice involved caring for AIDS patients and if that clinical practice involved direct physical care of patients. A lack of direct physical contact with AIDS patients may lessen fears of contagion and, subsequently, decrease negative attitudes toward patients with AIDS.

More has been learned about AIDS since Kelly et al.'s studies. Nursing faculty may manifest more positive attitudes toward patients with AIDS because their increased knowledge regarding the disease and its epidemiology

has decreased the fear of contagion. This is supported by Lawrence and Lawrence (1989) who found a positive relationship between knowledge of and attitudes about AIDS. They also found that nurses with graduate degrees had the highest knowledge base and the most positive attitudes about AIDS.

Limitations Which Became Apparent During Data Analysis

The gender of the population was found to be almost 100 percent female. This differed from Kelly et al.'s studies and may account for some differences in study results.

Another limitation which became apparent was the definition of clinical practice. Kelly et al. studied physicians, medical students, and nurses. Their clinical practice is tied closely to direct patient contact. Faculty members may interpret clinical practice more broadly to include direct hands-on care, supervision, consultation, or research. The type of clinical practice was not known and could influence the results of the study. Another aspect of clinical practice which was not determined but could have influenced the results of the study was the amount of personal contact participants had with AIDS and or male homosexual patients.

Recommendations for Further Study

The following recommendations are made for future research:

1. Modify the design to address the identified limitation, then expand the study by utilizing a larger random sample from various parts of the country.

2. A modified replication of the study with student nurses is recommended to help in designing curricula to meet students' needs regarding knowledge of AIDS and attitudes toward patients with a homosexual lifestyle.

3. A study of correlations between variables such as age, religion, educational background, and attitudes toward patients with AIDS and patients with a homosexual lifestyle should be completed.

4. A comparison of attitudes of nursing faculty to clinical nurses regarding homosexual patients and AIDS patients.

APPENDIX A

LETTER TO DEANS

845 Saddlebrook N.
Bedford, Texas 76021

Dean (Name)
School of Nursing
College/University
City, State

Dear Dean (Name):

You are invited to assist in a study of nursing faculty attitudes toward AIDS by providing a list of all your part-time and full-time faculty members.

The literature has described many negative attitudes among health professionals toward AIDS and patients with AIDS. Dr. Jeffrey Kelly, a frequent researcher and writer on the subject, suggests that this problem be addressed in the curricula of medical, nursing, and other health professional schools. He also says before faculty can effectively address the problem they must be aware of their own attitudes toward AIDS and patients with AIDS.

This study is designed to identify the attitudes of nursing faculty toward patients with AIDS and patients with a gay lifestyle. Each faculty member will be asked to read one of four vignettes describing a patient who is homosexual with AIDS, heterosexual with AIDS, homosexual with lung cancer, or heterosexual with lung cancer. They will then be asked to respond to three inventories based on their response to the vignette.

The proposal for the study has been approved by both my dissertation committee and by the Human Subjects Committee. My committee chairman is Dr. Dwane Kingery, Professor of Education at the University of North Texas in Denton.

A stamped, self-addressed envelope is enclosed for your convenience to return the list of faculty names to me. Thank you for your assistance in this study.

Sincerely,

Carol A. Reynolds, R.N., M.S.
Doctoral Candidate
University of North Texas

Telephone: (H) 817-282-0279; (W) 817-882-3333

APPENDIX B

LETTER TO FACULTY

845 Saddlebrook N
Bedford, Texas 76021

Faculty Member (Name)
School of Nursing
University
City, State

Dear Faculty Member (Name):

You are invited to participate in a study that seeks to identify nursing faculty attitudes toward selected groups of patients. Attitudes can be either positive or negative and in either case can affect not only your interaction with patients but affect how you assist students in dealing with their attitudes toward patients.

Enclosed you will find a biographical data sheet which we ask you to complete. Next you will find a vignette describing a patient followed by a series of opinion inventories. Please read the vignette and then complete the opinion inventories according to the directions. Upon completion put the vignette, the completed biographical sheet, and the completed inventories in the self-addressed, stamped envelope and return by May 30. Your responses will be kept completely confidential.

This study has been approved by the College of Higher Education, University of North Texas in Denton and is being conducted in partial fulfillment of the Doctor of Philosophy degree in higher Education Administration. We are most grateful for your time and attention and will be happy to send you summary data following completion of the study if you so desire. Your completion of the biographical sheet and opinion inventories constitutes your consent to participate in the study.

Your participation will be appreciated.

Sincerely,

Carol A. Reynolds, R.N., M.S.
Doctoral Candidate
University of North Texas

APPENDIX C

BIOGRAPHICAL DATA TOOL

Biographical Sheet

1. Age: _____25-35
   _____36-45
   _____46-55
   _____over 55

2. Sex: _____Female
   _____Male

3. Religion: _____Catholic
   _____Protestant
   _____Jewish
   _____Other (Specify)_____

4. Number of years in nursing: _____1-10
   _____11-20
   _____over 20

5. Basic nursing preparation: _____AD
   _____Diploma
   _____Baccalaureate

6. Master's Degree: _____in nursing
   _____outside nursing (Specify)_____

7. If Master's in nursing what is area of Master's specialty:

   _____Administration/Management
   _____Community/Public Health
   _____Medical-Surgical
   _____Ob/Gyn
   _____Pedi
   _____Psych/Mental Health
   _____Other (Specify)_____

8. Doctoral Degree: _____in nursing
   _____outside nursing (Specify)_____
   _____none

9. Number of years in teaching: _____1-10
   _____11-20
   _____over 20

10. Type of program in which you teach:
_____Associate Degree
_____Baccalaureate Only
_____Master's Only
_____Baccalaureate/Masters
_____Master's/Doctoral
_____Doctoral
_____Other (Specify)_____

11. Type of institution in which you teach:
_____Private institution
_____Public institution

12. Hours per week in clinical area with students:
_____0
_____1-5
_____6-10
_____11-15
_____16-20
_____Over 20 hours

13. Practice setting when with students:
_____Hospital
_____Comm./Pub. Health Agency
_____Office
_____Nsg. Home/Ext. Care Facility

14. Hours per week in personal clinical practice apart from students:

_____0
_____1-5
_____6-10
_____11-15

15. Practice setting for personal clinical practice:

_____Hospital
_____Comm./Pub. Health Agency
_____Nsg. Home/Ext. Care Facility
_____Office
_____Private Practice

APPENDIX D

VIGNETTES A, B, C, AND D

Vignette A

Following graduation from college, Mark accepted a management trainee position with a large computer manufacturing firm. His solid work performance won him the respect of his supervisors and he has advanced rapidly on the corporate ladder. At 32, he is the youngest division manager in the firm and has 55 employees working for him. Mark has always been active in his leisure time. In the summer he spends many weekends sailing on a small sloop he bought several years ago and often plays a game of tennis in the evening after work. He usually takes his vacation during the winter months so he can enjoy his favorite winter sport, skiing.

Within the last year Mark's life has changed in unexpected ways. For some time, he just didn't feel his usual self. He was frequently tired, felt run down and unenergetic, and had constant bouts of colds, flu, and infections which took longer than usual to heal. He has always been in excellent health. He finally decided to see a physician. After several visits and a number of tests, Mark learned that as a result of his gay lifestyle, he has contracted AIDS. The diagnosis came as a searing shock to Mark and has dramatically changed his life. Physically, he fights a constant battle against fatigue and recurrent illnesses which seem to last unceasingly. Although he continues to exercise, he can barely walk a mile each morning instead of the four miles he used to run in the morning before he left for work. He has lost weight and looks sallow. Friends who haven't seen him for a while comment on his changed appearance when they meet. Mark doesn't know whether or not to tell them he has AIDS. Mark has done quite a bit of reading recently about AIDS and knows that he will probably die in the next year or two, but hopes by taking care of himself that he may live a little longer.

Loneliness has become a major problem for the first time in Mark's life. Mark has always had a constant circle of friends and an active social life. Yet, the first few friends he turned to for emotional support after learning he had AIDS seemed uncomfortable with him. Recently, when he returned to the doctor's office for a checkup, the staff seemed unsupportive and distant. As his illness progresses, he realizes his job performance is not up to its old standards. He has not told anyone at work that he has AIDS, but people are beginning to ask questions and comment on his changed appearance. He's becoming very anxious about losing his job and feels that it's just a matter of time before either he isn't able to work any longer or is fired. He's doing the best he can on the job, but the constant illnesses and fatigue have taken their toll and he just doesn't have as much energy anymore.

Life has become a strain at home, too. After telling his life partner, Robert, that he has AIDS, Mark has felt very alone. For a week or two, Robert was sympathetic and supportive. When Mark first told him he had AIDS, Robert held him as they both cried and Robert said he'd be there faithful until the end to help care for Mark. But now Robert is increasingly distant and reserved. Robert seems more preoccupied with himself these days and has become very uncaring. Although they have been together for nine years and had a stable, affectionate relationship, Robert now stays away from the apartment almost all his waking hours, comes in late, and then sleeps on the sofa in the living room instead of in their bedroom. Two nights ago Robert told Mark he is planning to move out as soon as he finds another place to live. They've meant a lot to one another and both cried some during the conversation, but Robert explained that he is feeling very confused right now and needs a chance to get off by himself and think things through.

When Mark told his parents about his illness, although they had always had a good relationship with one another, they became very emotional. They haven't offered him much emotional support or understanding and just don't seem to want to talk about it.

Vignette B

Following graduation from college, Mark accepted a management trainee position with a large computer manufacturing firm. His solid work performance won him the respect of his supervisors and he has advanced rapidly on the corporate ladder. At 32, he is the youngest division manager in the firm and has 55 employees working for him. Mark has always been active in his leisure time. In the summer he spends many weekends sailing on a small sloop he bought several years ago and often plays a game of tennis in the evening after work. He usually takes his vacation during the winter months so he can enjoy his favorite winter sport, skiing.

Within the last year Mark's life has changed in unexpected ways. For some time, he just didn't feel his usual self. He was frequently tired, felt run down and unenergetic, and had constant bouts of colds, flu, and infections which took longer than usual to heal. He had always been in excellent health. He finally decided to see a physician. After several visits and a number of tests, Mark learned that as a result of an earlier blood transfusion, he has AIDS. The diagnosis came as a searing shock to Mark and has dramatically changed his life. Physically, he fights a constant battle against fatigue and recurrent illnesses which seem to last unceasingly. Although he continues to exercise, he can barely walk a mile each morning instead of the four miles he used to run in the morning before he left for work. He has lost weight and looks sallow. Friends who haven't seen him for a while comment on his changed appearance when they meet. Mark doesn't know whether or not to tell them he has AIDS. mark has done quite a bit of reading recently about AIDS and knows that he will probably die in the next year or two, but hopes by taking care of himself that he may live a little longer.

Loneliness has become a major problem for the first time in Mark's life. Mark has always had a constant circle of friends and an active social life. Yet, the first few friends he turned to for emotional support after learning he had AIDS seemed uncomfortable with him. Recently, when he returned to the doctor's office for a checkup, the staff seemed unsupportive and distant. As his illness progresses, he realizes his job performance is not up to its old standards. He has not told anyone at work that he has AIDS, but people are beginning to ask questions and comment on his changed appearance. He's becoming very anxious about losing his job and feels that it's just a matter of time before either he isn't able to work any longer or is fired. He's doing the best he can on the job, but the constant illnesses and fatigue have taken their toll and he just doesn't have as much energy anymore.

Life has become a strain at home, too. After telling his partner, Roberta, that he has AIDS, Mark has felt very alone. For a week or two, Roberta was sympathetic and supportive. When Mark first told her he had AIDS, Roberta held him as they both cried and Roberta said she'd be there faithful until the end to help care for Mark. But now Roberta is increasingly distant and reserved. Roberta seems more preoccupied with herself these days and has become very uncaring. Although they have been together for nine years and had a stable, affectionate relationship, Roberta now stays away from the apartment almost all her waking hours, comes in late, and then sleeps on the sofa in the living room instead of in their bedroom. Two nights ago Roberta told Mark she is planning to move out as soon as she finds another place to live. They've meant a lot to one another and both cried some during that conversation, but Roberta explained that she is feeling very confused right now and needs a chance to get off by herself and think things through.

When Mark told his parents about his illness, although they had always had a good relationship with one another, they became very emotional. They haven't offered him much emotional support or understanding and just don't seem to want to talk about it.

Vignette C

Following graduation from college, Mark accepted a management trainee position with a large computer manufacturing firm. His solid work performance won him the respect of his supervisors and he has advanced rapidly on the corporate ladder. At 32, he is the youngest division manager in the firm and has 55 employees working for him. Mark has always been active in his leisure time. In the summer he spends many weekends sailing on a small sloop he bought several years ago and often plays a game of tennis in the evening after work. He usually takes his vacation during the winter months so he can enjoy his favorite winter sport, skiing.

Within the last year Mark's life has changed in unexpected ways. For some time, he just didn't feel his usual self. He was frequently tired, felt run down and unenergetic, and had constant bouts of colds, flu, and infections which took longer than usual to heal. He had always been in excellent health. He finally decided to see a physician. After several visits and a number of tests, Mark learned that as a result of his fifteen year 2-3 pack per day smoking habit, he has metastatic bronchogenic lung cancer. The diagnosis came as a searing shock to Mark and has dramatically changed his life. Physically, he fights a constant battle against fatigue and recurrent illnesses which seem to last unceasingly. Although he continues to exercise, he can barely walk a mile each morning instead of the four miles he used to run in the morning before he left for work. He has lost weight and looks sallow. Friends who haven't seen him for a while comment on his changed appearance when they meet. Mark doesn't know whether or not to tell them he has metastatic lung cancer. Mark has done quite a bit of reading recently about metastatic lung cancer and knows that he will probably die in the next year or two, but hopes by taking care of himself that he may live a little longer.

Loneliness has become a major problem for the first time in Mark's life. Mark has always had a constant circle of friends and an active social life. Yet, the first few friends he turned to for emotional support after learning he had metastatic lung cancer seemed uncomfortable with him. Recently, when he returned to the doctor's office for a checkup, the staff seemed unsupportive and distant. As his illness progresses, he realizes his job performance is not up to its old standards. He has not told anyone at work that he has metastatic lung cancer, but people are beginning to ask questions and comment on his changed appearance. He's becoming very anxious about losing his job and feels that it's just a matter of time before either he isn't able to work any longer or is fired. He's doing the best he can on the job, but the constant illnesses and fatigue have taken their toll and he just doesn't have as much energy anymore.

Life has become a strain at home, too. After telling his partner, Robert, that he has metastatic bronchogenic lung cancer Mark has felt very alone. For a week or two, Robert was sympathetic and supportive. When Mark first told him he had metastatic bronchogenic lung cancer, Robert held him as they both cried and Robert said he'd be there faithful until the end to help care for Mark. But now Robert is increasingly distant and reserved. Robert seems more preoccupied with himself these days and has become very uncaring. Although they have been together for nine years and had a stable, affectionate relationship, Robert now stays away from the apartment almost all his waking hours, comes in late, and then sleeps on the sofa in the living room instead of in their bedroom. Two nights ago Robert told Mark he is planning to move out as soon as he finds another place to live. They've meant a lot to one another and both cried some during that conversation, but Robert explained that he is feeling very confused right now and needs a chance to get off by himself and think things through.

When Mark told his parents about his illness, although they had always had a good relationship with one another, they became very emotional. They haven't offered him much emotional support or understanding and just don't seem to want to talk about it.

Vignette D

Following graduation from college, Mark accepted a management trainee position with a large computer manufacturing firm. His solid work performance won him the respect of his supervisors and he has advanced rapidly on the corporate ladder. At 32, he is the youngest division manager in the firm and has 55 employees working for him. Mark has always been active in his leisure time. In the summer he spends many weekends sailing on a small sloop he bought several years ago and often plays a game of tennis in the evening after work. He usually takes his vacation during the winter months so he can enjoy his favorite winter sport, skiing.

Within the last year Mark's life has changed in unexpected ways. For some time, he just didn't feel his usual self. He was frequently tired, felt run down and unenergetic, and had constant bouts of colds, flu, and infections which took longer than usual to heal. He had always been in excellent health. He finally decided to see a physician. After several visits and a number of tests, Mark learned that as a result of his 15 year 2-3 pack per day smoking habit, he has metastatic bronchogenic lung cancer. The diagnosis came as a searing shock to Mark and has dramatically changed his life. Physically, he fights a constant battle against fatigue and recurrent illnesses which seem to last unceasingly. Although he continues to exercise, he can barely walk a mile each morning instead of the four miles he used to run in the morning before he left for work. He has lost weight and looks sallow. Friends who haven't seen him for a while comment on his changed appearance when they meet. Mark doesn't know whether or not to tell them he has metastatic bronchogenic lung cancer. Mark has done quite a bit of reading recently about metastatic bronchogenic lung cancer and knows that he will probably die in the next year or two, but hopes by taking care of himself that he may live a little longer.

Loneliness has become a major problem for the first time in Mark's life. Mark has always had a constant circle of friends and an active social life. Yet, the first few friends he turned to for emotional support after learning he had metastatic bronchogenic lung cancer seemed uncomfortable with him. Recently, when he returned to the doctor's office for a checkup, the staff seemed unsupportive and distant. As his illness progresses, he realizes his job performance is not up to its old standards. He has not told anyone at work that he has metastatic bronchogenic lung cancer, but people are beginning to ask questions and comment on his changed appearance. He's becoming very anxious about losing his job and feels that it's just a matter of time before either he isn't able to work any longer or is fired. He's doing the best he can on the job, but the constant illnesses and fatigue have taken their toll and he just doesn't have as much energy anymore.

Life has become a strain at home, too. After telling his partner, Roberta, that he has metastatic bronchogenic lung cancer, Mark has felt very alone. For a week or two, Roberta was sympathetic and supportive. When Mark first told her he had metastatic bronchogenic lung cancer, Roberta held him as they both cried and Roberta said she'd be there faithful until the end to help care for Mark. But now Roberta is increasingly distant and reserved. Roberta seems more preoccupied with herself these days and has become very uncaring. Although they have been together for nine years and had a stable, affectionate relationship, Roberta now stays away from the apartment almost all her waking hours, comes in late, and then sleeps on the sofa in the living room instead of in their bedroom. Two nights ago Roberta told Mark she is planning to move out as soon as she finds another place to live. They've meant a lot to one another and both cried some during that conversation, but Roberta explained that she is feeling very confused right now and needs a chance to get off by herself and think things through.

When Mark told his parents about his illness, although they had always had a good relationship with one another, they became very emotional. They haven't offered him much emotional support or understanding and just don't seem to want to talk about it.

APPENDIX E

EVALUATION INVENTORIES

Inventory I

Extremely assertive	1	2	3	4	5	6	7	Extremely unassertive
Extremely inappropriate	1	2	3	4	5	6	7	Extremely appropriate
Extremely untactful	1	2	3	4	5	6	7	Extremely tactful
Extremely inoffensive	1	2	3	4	5	6	7	Extremely offensive
Extremely truthful	1	2	3	4	5	6	7	Extremely untruthful
Extremely uneducated	1	2	3	4	5	6	7	Extremely educated
Extremely friendly	1	2	3	4	5	6	7	Extremely unfriendly
Extremely disagreeable	1	2	3	4	5	6	7	Extremely agreeable
Extremely unpleasant	1	2	3	4	5	6	7	Extremely pleasant
Extremely considerate	1	2	3	4	5	6	7	Extremely inconsiderate
Extremely flexible	1	2	3	4	5	6	7	Extremely inflexible
Extremely open-minded	1	2	3	4	5	6	7	Extremely closed-minded
Extremely sympathetic	1	2	3	4	5	6	7	Extremely unsympathetic
Extremely bad natured	1	2	3	4	5	6	7	Extremely good natured
Extremely fair	1	2	3	4	5	6	7	Extremely unfair
Extremely kind	1	2	3	4	5	6	7	Extremely unkind
Extremely dishonest	1	2	3	4	5	6	7	Extremely honest
Extremely unlikable	1	2	3	4	5	6	7	Extremely likeable
Extremely intelligent	1	2	3	4	5	6	7	Extremely unintelligent
Extremely thoughtless	1	2	3	4	5	6	7	Extremely thoughtful
Extremely attractive	1	2	3	4	5	6	7	Extremely unattractive
Extremely socially skilled	1	2	3	4	5	6	7	Extremely socially unskilled
Extremely warm	1	2	3	4	5	6	7	Extremely cold
Extremely superior	1	2	3	4	5	6	7	Extremely inferior

(Continue to the Next Page for Inventory II)

Inventory

	Not at all						Very much
1. Mark is responsible for his illness	1	2	3	4	5	6	7
2. Mark deserves sympathy and understanding	1	2	3	4	5	6	7
3. Mark deserves what has happened to him	1	2	3	4	5	6	7
4. Mark's illness has been traumatic for him	1	2	3	4	5	6	7
5. Mark has a lot of pain and suffering	1	2	3	4	5	6	7
6. Mark is dangerous to other people	1	2	3	4	5	6	7
7. Mark deserves the best medical care possible	1	2	3	4	5	6	7
8. Mark deserves to die	1	2	3	4	5	6	7
9. The world would be better off without Mark	1	2	3	4	5	6	7
10. Suicide might be the best solution for Mark	1	2	3	4	5	6	7
11. Mark should be quarantined so he does not expose others	1	2	3	4	5	6	7
12. Mark deserves to lose his job	1	2	3	4	5	6	7

(Continue to the Next Page for Inventory III)

Inventory III

	Disagree						Agree
1. If you met Mark, would you be willing to strike up a conversation with him?	1	2	3	4	5	6	7
2. Would you attend a party where Mark was present?	1	2	3	4	5	6	7
3. Would you attend a party where Mark was preparing dinner?	1	2	3	4	5	6	7
4. Would you be willing to work in the same office with Mark?	1	2	3	4	5	6	7
5. If you were a friend of Mark's, would you be willing to continue the friendship at this time?	1	2	3	4	5	6	7
6. Mark's lease is up in two months. If you were his landlord, would you renew his lease?	1	2	3	4	5	6	7
7. Would you allow your children to visit Mark in his home?	1	2	3	4	5	6	7

APPENDIX F

PARTICIPANTS' BIOGRAPHICAL DATA SUMMARY

TABLE 4

AGE RANGE AND GENDER OF PARTICIPANTS

Variable	Number of Participants N = 70	Percentage of Total
	Age Range	
25 - 35	9	12.9
36 - 45	24	34.3
46 - 55	21	30.0
> 55	15	21.4
Missing	1	1.4
	Gender	
Male	4	5.7
Female	65	92.9
Missing	1	1.4

TABLE 5

RELIGIOUS AFFILIATION OF PARTICIPANTS

Variable	Number of Participants N = 70	Percentage of Total
	Religion	
Catholic	8	11.4
Protestant	55	78.6
Jewish	1	1.4
Other	4	5.7
Missing	2	2.9

TABLE 6

NUMBER OF YEARS IN NURSING OF PARTICIPANTS

Variable	Number of Participants N = 70	Percentage of Total
	Years in Nursing	
1 - 10	2	2.9
11 - 20	27	38.6
> - 20	40	57.1
Missing	1	1.4

TABLE 7

BASIC NURSING PREPARATION OF PARTICIPANTS

Variable	Number of Participants N = 70	Percentage of Total
	Program Type	
Associate degree	4	5.7
Diploma	21	30.0
Baccalaureate	43	61.4
Missing	2	2.9

TABLE 8

ADVANCED NURSING PREPARATION AND PRACTICE SPECIALIZATION OF PARTICIPANTS

Variable	Number of Participants N = 70	Percentage of Total
Advanced Preparation		
Nursing masters	65	92.9
Non-nursing masters	3	4.3
Missing	2	2.9
Specialty		
Administrative	1	1.4
Community	5	7.1
Medical-surgical	31	44.3
OB/Gyn	10	14.3
Pediatrics	4	5.7
Psychiatry	9	12.9
Other	5	7.1
Missing	5	7.1

TABLE 9

DOCTORAL PREPARATION OF PARTICIPANTS

Variable	Number of Participants N = 70	Percentage of Total
In nursing	16	22.9
Outside nursing	17	24.3
None	20	28.6
Missing	17	24.3

TABLE 10

TEACHING EXPERIENCE OF PARTICIPANTS

Variable	Number of Participants N = 70	Percentage of Total
Years of Teaching		
1 - 10	30	42.9
11 - 20	24	34.3
> 20	15	21.4
Missing	1	1.4
Type of Program		
Associate degree	18	25.7
Baccalaureate	28	40.0
Baccalaureate/masters	19	27.1
Masters	4	5.7
Missing	1	1.4
Type of Institution		
Private	19	27.1
Public	50	71.4
Missing	1	1.4

TABLE 11

TEACHING CLINICAL HOURS AND SETTINGS OF PARTICIPANTS

Variable	Number of Participants N = 70	Percentage of Total
Practicum Hours		
0	11	15.7
1 - 5	3	4.3
6 - 10	14	20.0
11 - 15	31	44.3
16 - 20	6	8.6
> 20	2	2.9
Missing	3	4.3
Practicum Setting		
None	11	15.7
Hospital	48	68.6
Community	3	4.3
Office	1	1.4
Nursing home	1	1.4
Missing	3	4.3

TABLE 12

PERSONAL CLINICAL HOURS AND SETTINGS OF PARTICIPANTS

Variable	Number of Participants N = 70	Percentage of Total
Personal Clinical Hours Per Week		
0	32	45.7
1 - 5	16	22.9
6 - 10	13	18.6
11 - 15	4	5.7
Missing	5	7.1
Setting for Personal Hours		
None	32	45.7
Hospital	21	30.0
Community	4	5.7
Nursing home	1	1.4
Office	2	2.9
Private practice	3	4.3
Missing	7	10.0

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